

Par. 1. Material Transmitted and Purpose – Transmitted with the Manual Letter are changes to Service Chapter 650-25, State and Community Programs Funded under the Older Americans Act Policies and Procedures Manual. The old language is struck through, and the new language is highlighted and underlined in red.

The manual is being revised to clarify existing policies, include previously issued policies in the electronic format, and correct typographical errors.

Definitions 650-25-10

Revise/delete/add the following:

<u>Dietary Reference Intakes (DRIs)</u>		<u>Quantitative estimates of nutrient intakes for use in planning and assessing healthy diets. The DRIs include several nutrient based reference value sets including:</u> <ul style="list-style-type: none">a. <u>Estimated Average Requirement (EAR): “the average daily nutrient intake level estimated to meet the requirements of half the healthy individuals in a particular life stage and gender group”;</u>b. <u>Recommended Dietary Allowances (RDA): “the average daily nutrient intake level sufficient to meet the nutrient requirements of nearly all (97 to 98%) healthy individuals in a particular life stage and gender group”;</u>c. <u>Adequate Intake (AI): “a recommended average daily nutrient intake level based on observed or</u>
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		<p><u>experimentally determined approximations or estimates of nutrient intake by a group (or groups) of healthy people that are assumed to be adequate –used when RDA cannot be determined”;</u></p> <p><u>d. Tolerable Upper Intake Level (UL): “the highest average daily nutrient intake level that is likely to pose no risk of adverse health effects to almost all individuals in the general population. As intake increases above the UL, the potential risk of adverse effects may increase”;</u> and</p> <p><u>e. Acceptable Macronutrient Distribution Range (AMDR): “range of intake for a particular energy source (macronutrients include carbohydrates, proteins, fats) that is associated with reduced risk of chronic disease while providing intakes of essential nutrients. If an individual consumes in excess of the AMDR, there is a potential of increasing the risk of chronic diseases and/or insufficient intakes of essential nutrients.</u></p>
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<u>Evidenced-Based Program</u>		<u>A research-based program that demonstrates that a specific practice(s) increases the likelihood of a positive outcome(s). The Administration for Community Living has outlined a three-tiered evidence-based criterion for Title III-D programs and services under the Older Americans Act.</u>
<u>Local Contact Agency (LCA) Operating</u>		<u>Day-to-day activities necessary to implement and maintain Local Contact Agency services.</u>
<u>Local Contact Agency (LCA) Services</u>		<u>Activities provided in conjunction with the Department of Human Services Medical Services Division and the Money Follows the Person (MFP) initiative to assist in the required review of nursing home consumers through the Minimum Data Set (MDS) – Section Q to inform the consumers of available services and supports for potential transition to community living. LCA services follow the ADRL Options Counseling principles and core competencies.</u>

Aging & Disability Resource LINK (ADRL) Options Counseling Service Standard, including Local Contact Agency (LCA) Services 650-25-26

ADRL Options Counseling is a person-centered, interactive, decision-support process whereby consumers, family members and/or significant others are supported in determining appropriate long-term care choices based on the consumer's needs, preferences, values, and individual circumstances. Options counselors ensure that consumers have considered a range of possibilities when making a decision about long-term services and supports, and they encourage planning for the future.

The foundation for ADRL Options Counseling is a strong information and assistance system. It is important to keep in mind that information should be customized based on the needs and preferences communicated by the consumer, and the options available in the community.

Another building block of ADRL Options Counseling is person-centered planning. Within person-centered planning, the options counselor and the consumer work in full partnership to guarantee that the consumer's values, experience, and knowledge drive the creation of an action plan as well as the delivery of services. Person-centered planning requires that the options counselors respect the consumer's autonomy when choosing services, even if the options counselor disagrees with the consumer's choices.

Examples of when ADRL Options Counseling is appropriate include, but are not limited to: an individual who prefers to remain at home but needs supports to do so, or when a family caregiver needs help to continue providing care in the community.

Options counseling is not a long-term service. For the most part, ADRL intensive options counseling relationships are short term, usually no more than 90 days.

Six core competencies of options counseling have been identified by the Aging and Disability Resource Center Technical Assistance Exchange (ADRC-TAE):

1. Determining the need for options counseling;
2. Assessing needs, values and preferences;

3. Understanding and educating about public and private sector resources;
4. Facilitating self-direction/self-determination;
5. Encouraging future orientation; and
6. Following-up.

ADRL Options Counseling training addresses strategies for each of the core competencies.

LCA Services follow the ADRL Options Counseling principles and core competencies.

Performance Standards 650-25-26-01

Eligible Consumers 650-25-26-01-01

1. Individuals 60 years of age and older.
2. Adults 18 years of age and older with a physical disability.
3. LCA only: Nursing facility residents who may require assistance in securing medical and long-term supports and services to return to community living. Residents must be referred by the nursing facility staff.

Location of Services 650-25-26-01-05

Initial contact may occur through telephone contact and is often the gateway to options counseling. ADRL Options Counseling usually occurs in a face to face interaction. In-person conversations can be more effective than telephone consultation, especially when it offers the opportunity to involve family members as well as the consumer.

LCA Services are initiated through referral by a nursing facility after a Minimum Data Set (MDS) – Section Q review indicates a potential transition to the community. Initial consultation for possible transition to the community and follow-up occur with the resident/family in the nursing facility.

**ADRL Operating Activities & LCA Operating Activities
650-25-26-01-10**

ADRL Operating and LCA Operating are billable units of service that addresses staff time necessary to perform the day-to-day activities to implement and maintain an ADRL or complete LCA Services. Examples include answering the phone, data entry/billing, program marketing and promotion activities, training, travel time, etc.

ADRL Operating does not include ADRL activities outlined in the Service Delivery Procedures section 650-25-26-10.

LCA Operating does not include LCA Services outlined in the Service Delivery Procedures section 650-25-26-11.

Contract entities will be required to report completed ADRL Operating and LCA Operating activities on a monthly basis. Reporting requirements will be outlined in the contractual document with the Department of Human Services.

ADRL Operating and LCA Operating units of service must be entered in the SAMS data system by the 15th of the month following the activity.

ADRL Service Delivery Characteristics/Activities 650-25-26-01-15

ADRL Information & Referral/Assistance (I & R/A) and ADRL Options Counseling must be delivered throughout the service area.

1. All requests for ADRL I & R/A must be responded to within two working days.
2. Provide ADRL I & R/A services. Requests for I & R/A may be received from an individual, family member, ADRL partner, another agency, etc. Determine if the request requires only I & R/A or if options counseling is needed. Completion of the ADRL Options Counseling Referral/Intake form may assist in making the determination.
 - a. If it is determined that only I & R/A is needed, information should be given or a referral(s) made. Services must be coordinated with other agencies to eliminate duplication and assure seamless access for optimal service delivery.

- b. If it is determined that options counseling is needed, the ADRL Options Counseling Referral/Intake form must be completed. If completed by another staff person, the information must be forwarded to an options counselor.
 - c. Enter the ADRL Options Counseling Referral/Intake form information in the SAMS data system by the 15th of the month following service delivery.
3. If it is determined that ADRL Options Counseling is needed, the options counselor shall:
 - a. Complete the SAMS ADRL Options Counseling assessment form. The options counselor must attempt to obtain necessary data to determine consumer needs, preferences, values, and individual circumstances using person-centered planning strategies.
 - b. Provide customized information and assistance based on information communicated by the consumer, allowing the consumer to explore alternatives and make independent choices of both the service(s) to be received and the entity to provide the service. Assist the consumer in planning for future long-term care support needs.
 - c. Develop an action plan.
 - d. Make referral(s), if indicated, to other agencies. Services must be coordinated with other agencies to eliminate duplication and assure seamless access for optimal service delivery.
 - e. Enter the completed SAMS ADRL Options Counseling assessment form data, including the action plan, referrals, and narratives in the SAMS data system by the 15th of the month following service delivery.
4. A follow-up contact (face-to-face, telephone, written correspondence or e-mail) must be made within 30 days of the assessment to finalize the consumer action plan or assure the consumer has made a successful connection to the needed supports and is satisfied with the services and choice of service provider(s). All contacts must be documented in the narrative section of the SAMS ADRL Options Counseling assessment form by the 15th of the month following service delivery. Documentation of each contact shall include:
 - The specific purpose of the contact;

- **A** brief descriptive statement of the interaction including consumer satisfaction (if applicable), and any service needs identified;
- **O**ptions discussed; and
- **An** action plan.

Documentation in the narrative section must support any subsequent contacts that are made.

If ADRL Benefits Counseling and/or ADRL Futures Planning are provided, the activity must be recorded in SAMS as a subservice of ADRL Options Counseling Follow-Up Contact [Service Delivery Procedure 4].

5. At the time that all action steps are completed or if there is no activity within a six-month period, the SAMS ADRL Options Counseling record must be updated to reflect "inactive"; the Narrative section must be updated to reflect that Options Counseling is no longer being provided. If the consumer is enrolled in another Title III or HCBS services, the record must remain active; the Narrative should be updated to reflect that Options Counseling is no longer being provided.
6. If, after the consumer record has been made inactive, a consumer and/or a new referral indicates the need for additional options counseling, the options counselor shall re-open the consumer record, review, and update the existing SAMS ADRL Options Counseling assessment form, and complete the action steps as identified in Section 650-25-26-01-15 (3)(a-e); (4); and (5).
7. Complete disaster/emergency contacts upon request from Aging Services Division.
8. Complete ADRL Evaluation/Quality Assurance activities as outlined in Section 650-25-26-01-15 (8).
9. ~~8.~~ A signed release of information document must be on file before information is shared or released.
10. ~~9.~~ Each case record must be maintained in an individualized file and secured in a locked file cabinet, a locked area, or an access coded computer program. At a minimum, the record should include the initial contact information, the SAMS ADRL Options Counseling assessment

form, all documentation, and the release of information form(s) as applicable.

LCA Service Delivery Characteristics/Activities 650-25-26-01-16

LCA Services must be delivered throughout the service area.

1. All requests for LCA Services must be responded to within three working days. A face-to-face visit (if applicable) must be completed within 15 working days.
2. Provide LCA Services: Requests for LCA Services can only be received from a nursing facility. Determine if the request requires only information and assistance or if LCA Community Transition is needed.
 - a. If it is determined that only information and assistance is needed, requested information should be given or assistance/consultation provided. Time spent on the call shall be billed to LCA Operating.
 - b. If it is determined that LCA Community Transition is needed, the nursing facility social worker or designated staff shall fax the LCA Referral Form to the options counselor.
3. If it is determined that LCA Community Transition is needed, upon receipt of the LCA Referral Form, the options counselor shall:
 - a. Contact nursing facility social worker or designated staff to discuss referral and other pertinent information. Determine a date/time for an on-site visit (to be conducted within 15 days of the referral) with the resident, other identified individuals, and the nursing facility social worker/designee. (Note: The nursing facility social worker/designee is responsible for handling logistics, setting up the visit with the resident and other identified individuals, etc.).
 - b. Conduct an on-site visit within 15 days of the referral. The options counselor must attempt to obtain necessary data to determine the resident's needs, preferences, values, and individual circumstances using person-centered planning strategies. (Note: The nursing facility social worker/designee is responsible for the discharge plan; the options counselor provides information on options that are available based on the resident's preferences).
 - c. Complete the LCA Service Activity Summary form. Documentation must include, at a minimum:

- Summary of the interaction and options discussed;
 - Determination as to whether or not the resident's needs can be met in a community setting;
 - Potential referrals to the MFP program or Medicaid (county social services), if applicable;
 - Potential referrals to community-based services; and
 - Next steps.
- d. Follow-up to determine if/when discharge will take place. The nursing facility social worker/designee is responsible for developing the discharge plan that includes a referral to ADRL Options Counseling, if the options counseling service is needed after discharge.
- e. Fax a copy of the LCA Referral Form and the LCA Service Activity Summary form to the MFP administrator. If the resident is eligible for MFP services, the MFP administrator will contact the applicable Center for Independent Living (CIL).
- f. LCA services end when the resident is discharged to the community (if indicated in discharge plan, ADRL Options Counseling will contact consumer to schedule options counseling visit).
- g. Enter information obtained from the LCA Referral Form and the LCA Service Activity Summary form in the SAMS ADRL Options Counseling assessment form; in the narrative section, document referral information, summary of the on-site visit, follow-up activities, and next steps in SAMS data system.
- h. Documentation and posting of Service Delivery must be completed by the 15th of the month following service delivery.
4. If a referral is made to the MFP program or county social services, the narrative section of the SAMS ADRL Options Counseling assessment form must be updated to reflect referral information and service delivery posted to reflect 'inactive'.
5. A signed release of information document must be on file before information is shared or released.
6. Each case record must be maintained in an individualized file and secured in a locked file cabinet, a locked area, or an access coded computer program. At a minimum, the record should include the initial contact information, the SAMS ADRL Options Counseling assessment

form, all documentation, and the release of information form(s) as applicable.

Billable Unit of Service 650-25-26-05

For billing purposes, an ADRL Operating and LCA Operating unit of service is based on a 15-minute increment. Unit cost reimbursement is outlined in the contract entity's contractual document with the Department of Human Services.

The maximum amount of funding available for ADRL Operating activities and LCA Operating activities is outlined in the ~~contract~~ legal entity's contractual document with the Department of Human Services.

ADRL and LCA Operating units of service must be entered in the SAMS data system by the 15th of the month following the activity.

When delivering individual ADRL consumer and individual LCA resident services, the contract entity must use the service billing unit system for each service procedure identified in the Service Delivery Procedures 650-25-26-10 & 650-25-26-11.

ADRL Information & Referral Activity (ADRL I & R/A) that does not result in options counseling is not a billable unit of service.

If ADRL Benefits Counseling and ADRL Futures Planning are provided, the activity must be recorded in SAMS as a subservice of ADRL Options Counseling Follow-Up Contact [Service Delivery Procedure 4].

Each billable unit of service received by a consumer and /or a resident must be recorded in the consumer's individual record in the SAMS data system by the 15th of the month following service delivery.

ADRL Service Delivery Procedures 650-25-26-10

The following service delivery procedures must be used for reimbursement through the ~~an Older Americans Act~~ contract:

1. ADRL Information & Referral/Assistance (ADRL I & R/A) – 1 Unit of Service (only if activity results in ADRL Options Counseling).

- a. Complete the ADRL Options Counseling Referral/Intake form. If completed by another staff person, the information must be forwarded to an options counselor.
- b. Enter the ADRL Options Counseling Referral/Intake form information in the SAMS data system ~~by the 15th of the month following service delivery.~~
- c. Documentation and posting of Service Delivery must be completed by the 15th of the month following service delivery.
- d. If a consumer record is re-opened [Service Delivery Procedure #6], the ADRL Information & Referral/Assistance (ADRL I & R/A) [Service Delivery Procedure#1] may be billed in addition to the four units of service to re-open the consumer record, as applicable.

2. ADRL Initial Options Counseling Assessment – 8 Units of Service

- a. Complete the SAMS ADRL Options Counseling assessment form. The options counselor must attempt to obtain data necessary to determine consumer needs, preferences, values, and individual circumstances using person-centered planning strategies.
- b. Provide customized information and assistance based on information communicated by the consumer, allowing the consumer to explore alternatives and make independent choices of both the service(s) to be received and the entity to provide the service. Assist the consumer in planning for future long-term care support needs.
- c. Develop an action plan.
- d. Make referral(s), if indicated, to other agencies. Services must be coordinated with other agencies to eliminate duplication and assure seamless access for optimal service delivery.
- e. Enter the completed SAMS ADRL Options Counseling assessment form data, including the action plan, referrals, and narratives in the SAMS data system ~~by the 15th of the month following service delivery.~~
- f. Documentation and posting of Service Delivery must be completed by the 15th of the month following service delivery.

3. ADRL Telephone Contact, E-mail, Written Correspondence, or Brief Face-to-Face Visit – 1 Unit of Service

- a. If needed to complete the ADRL options counseling process, a referral entity or consumer may be contacted via telephone, e-mail, written correspondence, or through a brief face-to-face visit (outside of the home) regarding a needed service or receipt of services.

- b. Document in the Narrative section of the SAMS ADRL Options Counseling assessment form the specific purpose of the contact and a brief descriptive statement of the interaction, including consumer satisfaction (if applicable) with the service ~~by the 15th of the month following service delivery.~~
 - c. Documentation and posting of Service Delivery must be completed by the 15th of the month following service delivery.
4. ADRL Options Counseling Follow-Up Contact – 2 Units of Service
 - a. A follow-up contact (telephone, e-mail, written correspondence, or through a brief face-to-face visit) must be made within 30 days of the assessment to finalize the consumer action plan or assure the consumer has made a successful connection to the needed supports and is satisfied with the services and choice of service provider(s).
 - b. If provided, ADRL Benefits Counseling and/or ADRL Futures Planning must be recorded in SAMS as a subservice of ADRL Options Counseling Follow-Up Contact [Service Delivery Procedure #4].
 - c. Up to two additional contacts may be made. Documentation in the narrative section must support any subsequent contacts that are made. Billing for ADRL Options Counseling Follow-up Contact beyond the two additional contacts must be approved by the Options Counseling Program Administrator.
 - d. All contacts must be documented in the narrative section of the SAMS ADRL Options Counseling assessment form ~~by the 15th of the month following service delivery.~~ Documentation of each contact shall include:
 - The specific purpose of the contact;
 - A brief descriptive statement of the interaction including any service needs identified;
 - Options discussed; and
 - An action plan.
 - e. Documentation and posting of Service Delivery must be completed by the 15th of the month following service delivery.
5. ADRL Options Counseling Inactivity – 1 Unit of Service
 - a. At the time that all action steps are completed or if there is no activity within 90 days, the SAMS ADRL Options Counseling record must be updated to reflect “inactive”; the Narrative section must be updated to reflect that Options Counseling is no longer being provided.

- b. If the consumer is enrolled in other Title III or HCBS services, the record must remain active; the Narrative should be updated to reflect that Options Counseling is no longer being provided.
 - c. The ADRL Options Counseling Satisfaction Survey and cover letter must be given or mailed to the consumer along with a Department of Human Services self-addressed envelope.
 - d. Documentation and posting of Service Delivery must be completed by the 15th of the month following service delivery.
6. ADRL Options Counseling Re-Open Consumer Record – 4 6 Units of Service
- a. If, after the consumer record has been made inactive, a consumer and/or a new referral indicate the need for additional options counseling, the options counselor shall re-open the consumer record, review, and complete a reassessment using the SAMS ADRL Options Counseling assessment form (in SAMS copy, review, and update assessment information). If applicable, Service Delivery Procedure #1, [ADRL Information & Referral/Assistance (ADRL I & R/A)] may be billed in addition to the four units of service to re-open the consumer record.
 - b. Provide customized information and assistance based on information communicated by the consumer, allowing the consumer to explore alternatives and make independent choices of both the service(s) to be received and the entity to provide the service. Assist the consumer in planning for future long-term care support needs.
 - c. Develop an action plan.
 - d. Make referral(s), if indicated, to other agencies. Services must be coordinated with other agencies to eliminate duplication and assure seamless access for optimal service delivery.
 - e. If provided, ADRL Benefits Counseling and/or ADRL Futures Planning must be recorded in the SAMS as a subservice ADRL Options Counseling Follow-up Contact [Service Delivery Procedure 4].
 - f. Enter the completed SAMS ADRL Options Counseling form data, including the action plan, referrals, and narratives in the SAMS data system ~~by the 15th of the month following service delivery.~~
 - g. Documentation and posting of Service Delivery must be completed by the 15th of the month following service delivery.

7. Disaster/Emergency Contact – 1 Unit of Service

- a. At the direction of the Aging Services Division, contact a consumer to assist in planning to assure the consumer's safety in the event of a disaster/emergency.
- b. Document in the Narrative section of the SAMS ADRL Options Counseling assessment form the specific purpose of the contact and a brief description of the consumer's plan for safety ~~by the 15th of the month following service delivery.~~
- c. Documentation and posting of Service Delivery must be completed by the 15th of the month following service delivery.

8. ADRL Evaluation/Quality Assurance – 1 Unit of Service

Aging Services Division seeks to determine the length of time a consumer who used the options counseling service to explore alternatives to nursing home placement (i.e. considered nursing home placement; was on a waiting list for nursing home placement; referred from a nursing home; referred from a home health agency; referred from a physician; or other) is able to maintain in the community after the options counseling process is completed (consumer has been made inactive and is no longer receiving options counseling).

- a. On a bi-monthly basis, contact the consumer to determine if he/she is still living in the community.
- b. Select the appropriate sub-service of SAMS ADRL Evaluation/Quality Assurance Service Delivery. If "Other" is selected, include referral source in documentation.
- c. Document in the Narrative section of the SAMS ADRL Options Counseling form the purpose of the contact and whether or not the consumer continues to reside in the community.
- d. Documentation and posting of Service Delivery must be completed by the 15th of the month following service delivery.

LCA Service Delivery Procedures 650-25-26-11

The following service delivery procedures must be used for reimbursement through the contract:

1. LCA Community Transition – 8 Units of Service

Upon receipt of the LCA Referral Form, the options counselor shall:

- a. Contact nursing facility social worker or designated staff to discuss referral and other pertinent information. Determine a date/time for an on-site visit (to be conducted within 15 days of the referral) with the resident, other identified individuals, and the nursing facility social worker/designee. (Note: The nursing facility social worker/designee is responsible for handling logistics, setting up the visit with the resident and other identified individuals, etc.).
- b. Conduct an on-site visit within 15 days of the referral. The options counselor must attempt to obtain necessary data to determine the resident's needs, preferences, values, and individual circumstances using person-centered planning strategies. (Note: The nursing facility social worker/designee is responsible for the discharge plan; the options counselor provides information on options that are available based on the resident's preferences).
- c. Complete LCA Service Activity Summary form. Documentation must include, at a minimum:
 - Summary of the interaction and options discussed;
 - Determination as to whether or not the resident's needs can be met in a community setting;
 - Potential referrals to MFP program or Medicaid (county social services), if applicable;
 - Potential referrals to community-based services; and
 - Next steps.
- d. Follow-up to determine if/when discharge will take place. The nursing facility social worker/designee is responsible for developing the discharge plan that includes a referral to ADRL Options Counseling, if the options counseling service is needed after discharge.
- e. Fax a copy of the LCA Referral Form and the LCA Service Activity Summary form to the MFP administrator. If the resident is eligible for MFP services, the MFP administrator will contact the applicable Center for Independent Living (CIL).
- f. LCA Services end when the resident is discharged to the community (if indicated in discharge plan, ADRL Options Counseling will contact consumer to schedule options counseling visit).
- g. Enter information obtained from the LCA Referral Form and the LCA Summary Activity form in SAMS ADRL Options Counseling assessment form; in the narrative section, document referral information,

summary of the on-site visit including interactions and options discussed, needs determination, referrals, and next steps.

- h. Documentation and posting of Service Delivery must be completed by the 15th of the month following service delivery.

2. LCA Telephone Contact, E-mail, Written Correspondence, or Brief Face-to-Face Visit – 1 Unit of Service

- a. If needed to complete the LCA Community Transition process, a referral entity, resident, or family member may be contacted via telephone, e-mail, written correspondence, or through a brief face-to-face visit regarding a needed service or receipt of services.
- b. Document in the Narrative section of the SAMS ADRL Options Counseling assessment form the specific purpose of the contact and a brief descriptive statement of the interaction and outcome(s).
- c. Documentation and posting of Service Delivery must be completed by the 15th of the month following service delivery.

3. LCA Follow-Up Contact – 2 Units of Service

- a. A follow-up contact (telephone, e-mail, written correspondence, or face-to-face visit) with the nursing facility may be needed to determine if discharge will take place or to complete the LCA Community Transition process.
- b. All follow-up contacts must be documented in the narrative section of the SAMS ADRL Options Counseling assessment form. Documentation of each contact shall include:
- The specific purpose of the contact;
 - A brief descriptive statement of the interaction; and
 - Outcome of the follow-up contact.
- c. Documentation and posting of Service Delivery must be completed by the 15th of the month following service delivery.

4. LCA Community Transition Inactivity – 1 Unit of Service

- a. If a referral is made to the MFP program or county social services, the narrative section of the SAMS ADRL Options Counseling assessment form must be updated to reflect referral information and service delivery posted to reflect 'inactive'.

- b. LCA Services end when the resident is discharged to the community (if indicated in discharge plan, ADRL Options Counseling will contact consumer to schedule options counseling visit). The Narrative section of the ADRL Options Counseling assessment form must be updated to reflect that the resident transitioned to the community.
- c. Documentation and posting of Service Delivery must be completed by the 15th of the month following service delivery.

Staffing Requirements 650-25-26-15

1. Minimum educational requirement: Bachelor's degree in a human service or related field, or three years experience working in a direct service capacity in a human service or related field;
2. Possess the knowledge of or willingness to learn of available community resources within the service area;
3. Possess the ability to develop rapport with older individuals and adults with physical disabilities;
4. Possess the ability to develop rapport with other agencies that provide assistance to older individuals and adults with physical disabilities;
5. Possess a valid driver's license and have access to an automobile;
6. Possess effective verbal, writing, and computer skills; and
7. Complete the Department's ADRL Options Counseling Training, MDS – Section Q training, and participates in additional trainings as required.

Administrative Requirements 650-25-26-25

Medical Services Division has administrative and financial responsibility for LCA Services; Older Americans Act requirements differ from MDS-Section Q and LCA requirements; therefore, the entity's Program Policies and Procedures Manual should address the Older Americans Act ADRL Options Counseling Service.

Planning/Evaluation Requirements 650-25-26-25-10

Revise/re-number as follows:

1. Assess/reassess needs of older individuals in the defined service area through program and service evaluations with provision for client input. Develop and maintain a report of the outcomes. Outcomes should be considered in planning for development of new services, continuation of existing services, and/or discontinuing an existing service.
2. Coordinate services within the community to avoid duplication.
3. Evaluate overall program to determine whether or not services were delivered, at what cost; and to what extent goals/objectives were met.
- ~~4. Conduct service evaluations with provision for client input; develop and maintain a report of the findings for utilization in planning.~~
- ~~5. Use information to implement, continue, expand, or end a particular service or activity.~~
- ~~6.~~ 4. Participate in Department of Human Services/Aging Services Division evaluation activities as requested.

Health Maintenance Program Service Standard 650-25-35**Delivery Characteristics 650-25-35-01-10**

Revise #2, #4, and #6 as follows:

2. Records must be maintained for each client and include at a minimum the following information: date of service; ~~follow-up provided; education and information provided client,~~ as applicable to the service; and other contact with client and/or his/her physician. Contract entities may choose to document each contact in a ~~provider~~ contract entity specific client record or in the Narrative Section of the web-based SAMS Health Maintenance Assessment form. Each record must be maintained in an individualized file and secured in a locked file cabinet, locked area, or a restricted computer program.

4. Perform health maintenance services as outlined in the Service Delivery Procedures. Information and education must be provided to each client in conjunction with the health service provided.
6. ~~Screening clinics~~ Health maintenance services must be held provided throughout the contract period in accordance with the Contract.

Service Delivery Procedures 650-25-35-10

Revise #2 d as follows:

- d. Procedure.
 - Prepare equipment using established sanitizing procedures.
 - Provide foot and nail care.
 - Clean and sanitize equipment.

Revise #3 for format consistency:

3. Home Visit – 6 Units of Service
 - a. ~~1.~~ Prepare and assemble equipment and materials needed for client contact.
 - b. ~~2.~~ Review client's chart/record.
 - c. ~~3.~~ Refer to specific screening for number of service units that apply to service(s) provided.
 - d. ~~4.~~ Clean and ~~replace~~ **sanitize** equipment.
 - e. ~~5.~~ Correspondence/referral/follow-up/phone calls.
 - f. ~~6.~~ Documentation/recording.

Planning/Evaluation Requirements 650-25-35-25-10

Revise/re-number as follows:

1. Assess/reassess needs of older individuals in the defined service area through program and service evaluations with provision for client input. Develop and maintain a report of the outcomes. Outcomes should be

considered in planning for development of new services, continuation of existing services, and/or discontinuing an existing service.

2. Coordinate services within the community to avoid duplication.
3. Evaluate overall program to determine whether or not services were delivered, at what cost; and to what extent goals/objectives were met.
4. ~~Conduct service evaluations with provision for client input; develop and maintain a report of the findings for utilization in planning.~~
5. ~~Use information to implement, continue, expand, or end a particular service or activity.~~
6. 4. Participate in Department of Human Services/Aging Services Division evaluation activities as requested.

Legal Assistance Program Service Standard 650-25-40

Delivery Characteristics 650-25-40-01-10

Revise #2 as follows:

2. Provide a toll free telephone line as outlined in the Contract ~~that has live coverage during the core hour/days of 8:00 am to 5:00 pm (CT) Monday through Friday. Inquiries must be answered within one working day.~~

Nutrition Program Service Standard 650-25-45

Performance Standards 650-25-45-01

Eligible Clients 650-25-45-01-01

Revise as follows:

1. Individuals age 60 and older and their spouses, regardless of age. ~~Individuals under age 60 (except for spouses) may receive a meal only when it will not deprive an eligible client the opportunity to receive a meal.~~ A home-delivered meal may be provided to the spouse of an eligible client, regardless of the spouse's age or condition, when receipt of the meal is in the best interest of the eligible home-delivered meals client.
2. Individuals under age 60 (except for spouses) must pay the full cost of service unless one of the criteria listed below (3, 4, or 5) is met.
3. Volunteers under age 60 providing meal services during meal hours. The contract entity may make a meal available if a specific criterion is included in the entity's Program Policies and Procedures Manual. Individuals under age 60 (except for spouses) may receive a meal only when it will not deprive an eligible client the opportunity to receive a meal.
4. Individuals with disabilities under age 60. The contract entity may make a meal nutrition services available to individuals with disabilities under age 60 who reside in a housing facility primarily occupied by older individuals where there is a Title III congregate meal site when provision of the service does not prevent the participation of individuals age 60 and older and their spouse. If home-delivered meals are offered at the meal site, the individual with a disability under age 60 must meet eligibility criteria as outlined in Section 650-24-45-01-10 (6). The individual is only eligible to receive nutrition services that are provided at the housing facility where he or she resides. Specific congregate housing facility meal sites must be identified in the contract and in the entity's Program Policies and Procedures Manual. Individuals under age 60 (except for spouses) may receive a meal only when it will not deprive an eligible client the opportunity to receive a meal.

5. Individuals under the age of 60 with disabilities residing with eligible clients. The contract entity may make a meal available to an individual with a disability who resides at home with an eligible individual if specific criteria are included in the entity's Program Policies and Procedure Manual. Individuals under age 60 (except for spouses) may receive a meal only when it will not deprive an eligible client the opportunity to receive a meal.

Delivery Characteristics 650-25-45-01-10

Revise #5a and b as follows:

5. Congregate meal service must address the following:
 - a. All eligible congregate meals clients who participate or plan to participate shall be requested to provide baseline data as outlined in the SAMS Congregate Meal Program Registration form and complete the Nutrition Screening Checklist. If a meal and the client are reported as a part of the State Program Report, baseline data (NAPIS data) and the Nutrition Screening Checklist must be completed. ~~The contract entity must attempt to obtain all data requested in the assessment. Contact information, demographic data, and the Nutrition Screening Checklist are required for federal reporting purposes. Contacts may be documented in the Narrative section of the SAMS Congregate Meal Program Registration form, as appropriate. The Nutrition Screening Checklist must be reviewed and updated in the SAMS data system within a consecutive 12-month period for congregate meals clients.~~
~~If the consumer resides within the service area as identified in the contract entity's Contract with the Department, a consumer record must be created and completed in SAMS.~~
Eligible congregate meal clients who may be one-time guests, visiting for a short time, etc., are required to complete the Congregate Registration Form. A SAMS Consumer Group posting cannot be used as service delivery for reimbursement purposes.
This assures compliance with federal reporting requirements under NAPIS and the State Program Report. ~~Non-compliance may result in non-payment for services.~~

~~A SAMS Consumer Group posting should be used only for those eligible consumers that are one time guests.~~

- b. Clients who request service may be required to sign up in advance of the date of the service ~~is desired~~ as identified in the contract entity's Program Policies and Procedures Manual.

Revise #6b (typo) and c as follows:

6. Home-delivered meals criteria include:

- If a ~~provider~~ **contract entity** delivers a meal to a congregate client during inclement weather [Reference: OAA Policies and Procedures Section 650-25-45-01-10(4 **5**)(f)]; or
 - If provisions for the delivery of a frozen, modified atmosphere packaging (MAP), or shelf stable meal for a congregate client as an emergency meal are included in the contract entity's Program Policies and Procedures Manual assuring service delivery in weather-related emergencies and in their disaster preparedness plan.
- c. Eligibility for home-delivered meals must be determined using the SAMS [Home Delivered Meal Program Registration](#) form. **If a meal and the client are reported as a part of the State Program Report, baseline data (NAPIS data), the Nutrition Screening Checklist and ADLs/IADLs must be completed.** Initial determination of eligibility may be accomplished by telephone. Within two weeks after beginning meal service, a home visit and the SAMS Home-Delivered Meal Program Registration form must be completed to verify eligibility. The Nutrition Services contract entity may accept program registration information from another Older Americans Act entity. Information must be recorded in the SAMS data system. Documentation must include verification of eligibility for individuals under the age of 60.

For continued home-delivered meal service, redetermination of eligibility must be completed every six months, or sooner, as needed. Redetermination can be accomplished through a home visit or by telephone. At a minimum, one home visit must occur within a consecutive 12-month period. The redetermination must be documented in the SAMS data system. Documentation must

indicate the method of redetermination (home visit or telephone)
and include verification of continued eligibility for individuals
under the age of 60.

Revise #7 and 7a as follows:

7. Nutrition education must be provided to both congregate and home-delivered meals clients by the Nutrition Services contract entity. A licensed registered dietitian or person with comparable expertise shall be requested to provide input regarding the content of the nutrition education prior to presentation or distribution of materials.
 - a. Nutrition education shall be provided at each congregate meal site on a semi-annual basis (minimum). Nutrition related presentations, printed materials, videos, food demonstrations, and cooking classes are acceptable formats for the provision of the service. Documentation indicating the meal site, date, presenter (as applicable), topic presented, number of clients receiving nutrition education, and the number of service units must be maintained. To record Service Delivery in the SAMS data system, a separate Consumer Group should be created for each meal site. Each client attending a presentation equals one unit of service.

Revise #8c and d as follows:

- c. Screening results for all clients must be recorded in the SAMS data system. Clients should be encouraged to 're-check' their nutritional scores as indicated: Score of 0-2 should recheck in 6 months; score of 3-5 should recheck in 3 months; score of 6 or more are at high nutritional risk – discuss (with the client) the possible referral ~~and should be referred to~~ their physician or licensed registered dietitian to ~~discuss~~ address nutritional concerns and ways to improve their nutritional health (see information in 7d).
 - d. Clients who screen 'at high nutritional risk' ~~shall be referred~~ should consider referral to a doctor or licensed registered dietitian for follow-up and possible nutrition counseling. The Nutrition Services contract entity shall discuss with the client and if written release is obtained, make a referral to the licensed registered dietitian providing services to the Nutrition Services

contract entity or to the client's physician. Documentation of the contract [contact and outcome](#) referral, or referral attempt must be recorded in the Narrative section of the applicable SAMS meal registration form.

Menu Planning 650-25-45-10

Delete #2 (moved to Definitions); and revise as follows:

- ~~2. Dietary Reference Intakes (DRIs) are quantitative estimates of nutrient intakes for use in planning and assessing healthy diets. The DRIs include several nutrient based reference value sets including:~~
 - ~~a. Estimated Average Requirement (EAR): "the average daily nutrient intake level estimated to meet the requirements of half the healthy individuals in a particular life stage and gender group";~~
 - ~~b. Recommended Dietary Allowances (RDA): "the average daily nutrient intake level sufficient to meet the nutrient requirements of nearly all (97 to 98%) healthy individuals in a particular life stage and gender group";~~
 - ~~c. Adequate Intake (AI): "a recommended average daily nutrient intake level based on observed or experimentally determined approximations or estimates of nutrient intake by a group (or groups) of healthy people that are assumed to be adequate—used when RDA cannot be determined";~~
 - ~~d. Tolerable Upper Intake Level (UL): "the highest average daily nutrient intake level that is likely to pose no risk of adverse health effects to almost all individuals in the general population. As intake increases above the UL, the potential risk of adverse effects may increase"; and~~
 - ~~e. Acceptable Macronutrient Distribution Range (AMDR): "range of intake for a particular energy source (macronutrients include carbohydrates, proteins, fats) that is associated with reduced risk of chronic disease while providing intakes of essential nutrients. If an individual consumes in excess of the AMDR, there is a potential of increasing the risk of chronic diseases and/or insufficient intakes of essential nutrients.~~
- ~~3.~~ 2. The South Dakota Division of Adult Services and Aging developed recipes and menus that meet current [dietary guidelines and](#) DRI

requirements. The menus were developed and nutritional analyses completed by Adele Huls, PhD, RD, LMNT, LN.

The recipes and menus are posted on the South Dakota website and are available for use by North Dakota providers contract entities. The recipes and menus can be accessed at:

<http://dss.sd.gov/elderlyservices/services/seniormeals/menusandrecipes.asp>

- 4- 3. Contract entities that do not use the menus developed by the South Dakota Division of Adult Services and Aging must address the following:
 - a. Develop menus that comply with the most recent Dietary Guidelines for Americans (DGs) and meet current DRI recommendations. North Dakota will follow guidelines used by South Dakota in the development of menus to meet current DRI requirements. Guidelines for nutrient values are listed in #5.
 - b. Use a cycle menu format (minimum of four weeks) that is rotated at set intervals and reflects seasonal availability of foods.
 - c. To the maximum extent practicable, consider the special dietary needs arising from health requirements, religious requirements, or ethnic backgrounds of eligible clients.
 - d. The cycle menus, recipes, and nutritional analysis must be submitted to Aging Services Division through the ~~request for proposal~~ procurement process and/or upon request. The submitted materials must be signed by the contract entity's licensed registered dietitian or licensed nutritionist.

- 3- 4. The following guidelines for nutrient values must be used in developing menus:

Nutrient	Value
Basic Components	
*denotes required	
*Calories (kcal)	735.00
Water	1233.30
*Protein (g) actual is 18.8 - our goal is based on 17% of calories and wt/ht/activity of reference person (75 yo male 68" 153#) Lightly Active	31.24
Carbohydrates (g) based on 53% of calories	97.40
*Dietary Fiber (g)	10.29
*Fat (g) based on 30% of calories - can be lower	24.50
Net Carbs	87.11
Vitamins	
*Vitamin A RAE	300.00
*Vitamin B-6 (mg)	0.60
*Vitamin B-12 (mcg)	0.80
*Vitamin C (mg)	30.00
Vitamin D (mg) (or 200 IU)	5.00
Folate DFE (mcg)	133.30
Minerals	
*Calcium (mg)	400.00
*Magnesium (mg)	140.00
Iron (mg)	2.70
*Sodium (mg) goal: 800 or less in future	1000.00
Potassium (mg) goal: 1567.0 in future	1250.00
*Zinc (mg)	3.75

Contract entities should strive to meet nutrient values on a daily basis. Averaging of nutrient values over a 5-day or 7-day period is allowable.

- 6- **5.** A meal pattern is a menu-planning tool that ensures the number/numbers of servings per food group are met at each meal. **Meal patterns do not ensure that nutrient requirements are met; therefore, computer-assisted nutrient analysis must be run** (see #5).

The following meal pattern is based on the 2005 Dietary Guidelines for Americans and the Food Guide Pyramid.

FOOD GROUP	SERVINGS PER MEAL	PORTION SIZE
Bread or Bread Alternative	2 servings	1 serving = 1/2 cup cooked pasta, rice or cereal; 1 slice of bread (1 oz.) or equivalent combinations
Vegetable	2 servings	1 serving = 1/2 cup or equivalent measure (may serve an additional vegetable instead of a fruit)
Fruit	1 serving	1 serving = 1/2 cup or equivalent measure (may serve an additional fruit instead of a vegetable)
Milk or Milk Alternative	1 serving	1 serving = 1 cup (8 oz) or equivalent measure
Meat or Meat Alternative	1 serving	1 serving = 2 oz or equivalent measure
Fats	1 serving	1 serving = 1 teaspoon or equivalent measure
Dessert	1 serving	1 serving = 1/2 cup (optional)

7. **6.** All menu changes/substitutions must be documented on the menu for site review. In making substitutions, consideration must be given to assure dietary compliance is met. It is recommended that a list of approved substitutions be maintained at the meal site.

- ~~8.~~ 7. Provision of a special or therapeutic diet to a client requires a signed physician's order. Menus must be planned with the advice of a licensed registered dietitian to establish appropriate nutritional therapy.
- ~~9.~~ 8. Nutrition Services contract entities are prohibited from providing vitamin and/or mineral supplements to clients.

Administration 650-25-45-30-01

Revise #1g as follows:

- g. Service contribution (program income) procedures that assure:
- i. Clients are provided the opportunity to contribute to the cost of services received. Acceptable formats for receiving contributions include the following: a sealed envelope given to the options counselor or returned by mail. Any form of periodic correspondence resembling a billing for number of services received by a client is prohibited.
 - ii. Upon initial registration for the service and periodically thereafter, inform the client of the opportunity to voluntarily contribute to the cost of the service.
 - iii. ~~ii.~~ No client is denied service due to inability or unwillingness to contribute.
 - iv. ~~iii.~~ A suggested contribution schedule that considers the income ranges of older individuals may be developed. Means tests shall not be used for any service supported by Older Americans Act funds.
 - v. ~~iv.~~ Each ~~service provider~~ contract entity must choose to do one of the following: 1) Publicly display at service locations and provide to clients served at home, the full cost of the nutrition service, with information that indicates that clients may, but are not required to contribute for the nutrition service; or 2) publicly display at service locations and provide to clients served at home, the full cost of the nutrition service and the suggested contribution, with information indicating that clients may, but are not required to contribute for the nutrition service.
 - vi. ~~v.~~ Measures are taken to protect the privacy of each client with respect to his or her contribution.
 - vii. ~~vi.~~ Appropriate procedures are established to safeguard and account for all contributions. At a minimum, the following must

be addressed: format used for receipt of funds, procedure for deposits, verification of receipt of funds, location of funds prior to deposit, and program staff who have access to the funds.

- viii. ~~vii.~~ Ineligible participants are required to pay the full cost of the nutrition service. (These funds are not program income).
- ix. ~~viii.~~ Service contributions for nutrition services are used to expand nutrition services.
- x. ~~ix.~~ Service contributions for nutrition services may include food stamps Supplemental Nutrition Assistance Program (SNAP) benefits.

Planning/Evaluation Requirements 650-25-45-30-10

Revise/re-number as follows:

1. Assess/reassess needs of older individuals in the defined service area through program and service evaluations with provision for client input. Develop and maintain a report of the outcomes. Outcomes should be considered in planning for development of new services, continuation of existing services, and/or discontinuing an existing service.
2. Coordinate services within the community to avoid duplication.
3. Evaluate overall program to determine whether or not services were delivered, at what cost; and to what extent goals/objectives were met.
4. ~~Conduct service evaluations with provision for client input; develop and maintain a report of the findings for utilization in planning.~~
5. ~~Use information to implement, continue, expand, or end a particular service or activity.~~
6. 4. Participate in Department of Human Services/Aging Services Division evaluation activities as requested.

Senior Companion Program Service Standard 650-25-55

Administration 650-25-55-10-01

Delete 1e; revise lettering as follows:

- e. ~~Service contribution (program income) procedures that assure:~~
 - i. ~~Recipients of the senior companion service are provided the opportunity to contribute to the cost of services received. Acceptable formats for receiving contributions include the following: sealed envelope given to senior companion volunteer or return by mail. Any form of periodic correspondence resembling a billing for number of services received by a client is prohibited.~~
 - ii. ~~No client is denied service due to inability or unwillingness to contribute.~~
 - iii. ~~A suggested contribution schedule that considers the income ranges of older individuals may be developed. Means tests shall not be used for any service supported by Older Americans Act funds.~~
 - iv. ~~Each service provider must choose to do one of the following: 1) Provide to clients served at home, the full cost of the senior companion service, with information indicating that clients may, but are not required to contribute for the senior companion service; or 2) Provide to clients served at home, the full cost of the senior companion service and the suggested contribution, with information indicating that clients may, but are not required to contribute for the senior companion service.~~
 - v. ~~Appropriate procedures are established to safeguard and account for all contributions. At a minimum, the following must be addressed: format used for receipt of funds, procedure for deposits, verification of receipt of funds, location of funds prior to deposit, and program staff who have access to funds.~~
 - vi. ~~Measures are taken to protect the privacy of each client with respect to his or her contribution.~~
 - vii. ~~Service contributions for senior companion services are to used expand senior companion services.~~
- f e. Fiscal procedures that address receipt of Older Americans Act and related funds, deposit of funds, and payment process.
- g f. Non-discrimination towards clients.

- h g. Grievance procedures for clients.
- i h. Records retention.
- j i. A plan to review and update manual as necessary but at least 90 days after the beginning of each contract period.

Planning/Evaluation Requirements 650-25-55-10-10

Revise/re-number as follows:

1. Assess/reassess needs of older individuals in the defined service area through program and service evaluations with provision for client input. Develop and maintain a report of the outcomes. Outcomes should be considered in planning for development of new services, continuation of existing services, and/or discontinuing an existing service.
 2. Coordinate services within the community to avoid duplication.
 3. Evaluate overall program to determine whether or not services were delivered, at what cost; and to what extent goals/objectives were met.
 4. ~~Conduct service evaluations with provision for client input; develop and maintain a report of the findings for utilization in planning.~~
 5. ~~Use information to implement, continue, expand, or end a particular service or activity.~~
4. Participate in Department of Human Services/Aging Services Division evaluation activities as requested.

Tribal Home Visit Service Standard 650-25-61

Service Delivery Characteristics/Activities 650-25-61-01-10

Revise #7 as follows:

7. If more than one ~~Per client billing for a tribal home visit may occur only one time during~~ within a thirty-day period, documentation must clearly justify the reason for the visit and outcome of the visit.

Service Delivery Procedures 650-25-61-10

Revise #1 to add letter **d** as follows:

1. Tribal Home Visit – 4 Units of Service

- a. Conduct a visit in the client's home. Complete the SAMS Tribal Visit Registration form to register the client in SAMS.
- b. If needed services are identified, make appropriate referrals; obtain a release of information, if applicable.
- c. Document the following in the Narrative section of the SAMS Tribal Visit Registration form:
 - The specific purpose of the home visit;
 - A brief descriptive statement of the interaction; and
 - Outcome of the interaction.
- d. Review and update information obtained on the SAMS Tribal Home Visit Registration Form in the SAMS data system (under Assessments, select Copy) within a consecutive 12-month period.

Planning/Evaluation Requirements 650-25-61-25-10

Revise/re-number as follows:

1. Assess/reassess needs of older individuals in the defined service area through program and service evaluations with provision for client input. Develop and maintain a report of the outcomes. Outcomes should be considered in planning for development of new services, continuation of existing services, and/or discontinuing an existing service.
2. Coordinate services within the community to avoid duplication.
3. Evaluate overall program to determine whether or not services were delivered, at what cost; and to what extent goals/objectives were met.
4. ~~Conduct service evaluations with provision for client input; develop and maintain a report of the findings for utilization in planning.~~
5. ~~Use information to implement, continue, expand, or end a particular service or activity.~~

- 6- ~~4.~~ Participate in Department of Human Services/Aging Services Division evaluation activities as requested.

Older Americans Act Title III Assessment Monitoring 650-25-65

Revise as follows:

~~Assessments are~~ Monitoring activities are conducted to determine the following:

- Compliance with state and federal rules, regulations and policies;
- Compliance with the terms of the contract and any attachments;
- If service provision meets or exceeds service standards and/or contract requirements, as applicable; and
- Factors that may have contributed to the achievement or lack of achievement in meeting service standards and/or contract requirements.

Using the Older Americans Act Title III Monitoring tool, on-site assessments monitoring must be are conducted by Department staff ~~a minimum of two times during~~ according to the schedule set forth by Aging Services Division. ~~One of the assessments must be a year-end assessment.~~ Department staff may conduct additional and/or more in-depth reviews based on specific circumstances and the needs of legal and contract entities. Regional Aging Services staff may request assistance from Aging Services Division staff in conducting ~~assessments/reviews~~ monitoring activities.

An exit conference will be held at the conclusion of each on-site monitoring activity ~~assessment/review~~ to summarize monitoring activities and outline non-compliance issues. ~~Contract~~ Legal entities must respond, in writing, to any non-compliance issues identified during the assessment process in the time frame set forth by Department staff. Follow-up will be conducted to assure appropriate action has been taken to address each non-compliance issue.

~~Assessments/reviews~~ Monitoring reports and written responses to non-compliance issues are forwarded to Aging Services Division for review and, if necessary, implementation of remedies. Failure to rectify issues of non-

compliance may result in non-payment, recapture of funds, or contract termination.

State Program Report 650-25-70-10

Delete paragraphs three and four as follows:

~~Through the procurement process, the Subcontracting and the Subcontracting Certification Forms will be forwarded to entities for completion and submission to Aging Services Division. Throughout the contract term, contract entities are responsible for updating and resubmission of any information contained on the forms, including any updated attachments to the forms. For any new subcontractors, including the substitution of one subcontractor for another, the contract entity must submit the following: Identifying Data Form that indicates the reason for resubmission; the Subcontracting Form; and the Subcontracting Certification Form(s), including a copy of the Secretary of State registration and any required license(s).~~

~~The new form(s) will become a part of the contract.~~

Procurement of Services 650-25-75-01

Delete the last paragraph as follows:

~~Requests for proposal are issued for health maintenance, legal, nutrition, and outreach services. All awards for other services are offered through the applicable procurement requirements.~~

Subcontract 650-25-75-05-01

Revise the second and third paragraphs as follows:

The Department of Human Services, Aging Services Division, requires the completion and submission of a Subcontracting Form that identifies each subcontractor and the percentage of work being performed by each. ~~Aging Services Division also requires the completion and submission of a Subcontractor Certification Form.~~

~~Through the procurement process, The Subcontracting and the Subcontracting Certification Forms will be forwarded to entities for completion and submission to Aging Services Division~~ will be forwarded to the legal entity through the procurement process. Throughout the contract term, ~~contract entities are~~ the legal entity is responsible for updating and resubmission of any information contained on the forms, including any updated attachments to the forms. The legal entity must submit changes using the Notification of Proposal Change Form. ~~For any new subcontractors, including the substitution of one subcontractor for another, the contract entity must submit the following: Identifying Data Form that indicates the reason for resubmission; the Subcontracting Form; and the Subcontracting Certification Form(s), including a copy of the Secretary of State registration and any required license(s).~~

Upon receipt of resubmission the resubmitted forms, the documents will be reviewed; acknowledgement of receipt and/or approval will be indicated by signature of the Director of Aging Services Division on the Identifying Data Form Notification of Proposal Change Form. A copy of the signed Identifying Data Form Notification of Proposal Change Form will be forwarded to the contract legal entity.

The new form(s) will become a part of the contract.

Service Provision Form 650-25-75-05-05

Revise as follows:

The Department of Human Services, Aging Services Division, requires the completion and submission of a Service Provision Form (~~applicable to nutrition and health services~~). The form(s) outlines location and frequency ~~communities, sites, frequency, etc., for the~~ of a specific funded service.

~~Through the procurement process, Aging Services Division will forward The Service Provision Form to entities for completion and submission to Aging Services Division~~ will be forwarded to the legal entity through the procurement process. Throughout the contract term, ~~contract entities are~~ the legal entity is responsible for updating and resubmission of any information contained on the Service Provision Form. The contract legal entity must submit the following: ~~Identifying Data Form that indicates the~~

~~reason for resubmission; and the updated Service Provision Form(s) submit~~
changes using the Notification of Proposal Change Form.

Upon receipt of resubmission the resubmitted forms, the documents will be reviewed; acknowledgement of receipt and/or approval will be indicated by signature of the Director of Aging Services Division on the Identifying Data Form Notification of Proposal Change Form. A copy of the signed Identifying Data Form Notification of Proposal Change Form will be forwarded to the contract legal entity. The contract legal entity must submit the following: Identifying Data Form that indicates the reason for resubmission; and the updated Service Provision Form(s) submit changes using the Notification of Proposal Change Form.

The new form(s) will become a part of the contract.

Identifying Data Form 650-25-75-05-10

Revise/delete paragraphs two, three, and four as follows:

~~Through the procurement process, Aging Services Division will forward The Identifying Data Form to entities for completion and submission to Aging Services Division~~ will be forwarded to the legal entity through the procurement process. Throughout the contract term, ~~contract entities are~~ the legal entity is responsible for updating and resubmission of any information contained on the Notification of Proposal Change Form. The legal entity must submit changes using the Notification of Proposal Change Form.

~~The Identifying Data Form must also be submitted with the resubmission of the Subcontracting Form, the Subcontractor Certification Forms, and the Service Provision Form(s). The Identifying Data Form must indicate the reason for resubmission of the specific form(s).~~

Upon receipt of resubmission the resubmitted forms, the documents will be reviewed; acknowledgment of receipt and/or approval will be indicated by signature of the Director of Aging Services Division on the Identifying Data Form. A copy of the signed Identifying Data Form Notification of Proposal Change Form will be forwarded to the contract legal entity.

The new form(s) will become a part of the contract.

Program Requirements Form 650-25-75-05-15

Revise as follows:

The Department of Human Services, Aging Services Division, requires the completion and submission of a Program Requirements Form. The form provides acknowledgment of review and understanding of program requirements, as well as acknowledgment that ~~assessments and reviews~~ monitoring activities will be conducted to assure that services are being provided according to requirements.

~~Through the procurement process, Aging Services Division will forward~~ The Program Requirements Form ~~to entities for completion and submission to Aging Services Division~~ will be forwarded to the legal entity through the procurement process. Throughout the contract term, ~~contract entities are~~ the legal entity is responsible for updating and resubmission of any information contained on the Program Requirements Form. The ~~contract~~ legal entity must submit changes using the Notification of Proposal Change Form. ~~the following: Identifying Data Form that indicates the reason for resubmission; and the updated Program Requirements Form.~~

Upon receipt of ~~resubmission~~ the resubmitted forms, the documents will be reviewed; acknowledgment of receipt and/or approval will be indicated by signature of the Director of Aging Services Division on the ~~Identifying Data~~ Notification of Proposal Change Form. A copy of the signed ~~Identifying Data~~ Notification of Proposal Change Form will be forwarded to the ~~contract~~ legal entity.

The new form(s) will become a part of the contract.

~~Project Management~~ Principal Officer & Board Members Form 650-25-75-05-20

Revise as follows:

The Department of Human Services, Aging Services Division, requires the completion and submission of a Project Management Principal Officers & Board Members Form. The form identifies the following:

- ~~a. the legal entity;~~
- ~~b. principle officers and board members by name and title; and~~

- c. ~~staff members involved in operating the project including a narrative description of the type of work performed, relevant credentials, including education and experience, and the full-time equivalent (FTE) percent of the project time commitment for each.~~

~~An organization chart (diagram form) that shows the structure of the organization, illustrating staff by name and title, lines of authority, and a current review date must be attached.~~

~~Through the procurement process, Aging Services Division will forward The Project Management Principal Officers & Board Members Form to entities for completion and submission to Aging Services Division will be forwarded to the legal entity through the procurement process. Throughout the contract term, the legal entity is contract entities are responsible for updating and resubmission of any information contained on the Principal Officers & Board Members Form. The contract legal entity must submit changes using the Notification of Proposal Change Form the following: Identifying Data Form that indicates the reason for resubmission; and the updated Project Management Form.~~

Upon receipt of resubmission the resubmitted forms, the documents will be reviewed; acknowledgment of receipt and/or approval will be indicated by signature of the Director of Aging Services Division on the Identifying Data Notification of Proposal Change Form. A copy of the signed Identifying Data Notification of Proposal Change Form will be forwarded to the contract legal entity.

The new form(s) will become a part of the contract.

Add new sections as follows:

Staff Information Form 650-25-75-05-25

The Department of Human Services, Aging Services Division, requires the completion and submission of a Staff Information Form. The form identifies staff involved in providing a specific service.

Upon request, an organization chart (diagram form) that shows the structure of the organization, illustrating staff by title, lines of authority, and a current review date must be submitted.

The Staff Information Form will be forwarded to the legal entity through the procurement process. Throughout the contract term, the legal entity is

responsible for updating and resubmission of any information contained on the Staff Information Form. The legal entity must submit changes using the Notification of Proposal Change Form.

Upon receipt of the resubmitted forms, the documents will be reviewed; acknowledgment of receipt and/or approval will be indicated by signature of the Director of Aging Services Division on the Notification of Proposal Change Form. A copy of the signed Notification of Proposal Change Form will be forwarded to the legal entity.

The new form(s) will become a part of the contract.

Nutrition Dietitian Services Form 650-25-75-05-30

The Department of Human Services, Aging Services Division, requires the completion and submission of a Dietitian Services Form for legal entities providing nutrition services. The form identifies the individual(s) providing dietitian services.

The Dietitian Services Form will be forwarded to the legal entity through the procurement process. Throughout the contract term, the legal entity is responsible for updating and resubmission of any information contained on the Dietitian Services Form. The legal entity must submit changes using the Notification of Proposal Change Form.

Upon receipt of the resubmitted forms, the documents will be reviewed; acknowledgment of receipt and/or approval will be indicated by signature of the Director of Aging Services Division on the Notification of Proposal Change Form. A copy of the signed Notification of Proposal Change Form will be forwarded to the legal entity.

The new form(s) will become a part of the contract.

Health Maintenance Professional Services Form 650-25-75-05-35

The Department of Human Services, Aging Services Division, requires the completion and submission of a Health Maintenance Professional Services Form for legal entities providing health maintenance services. The form identifies the individual(s) providing health maintenance services.

The Health Maintenance Professional Services Form will be forwarded to the legal entity through the procurement process. Throughout the contract term, the legal entity is responsible for updating and resubmission of any information contained on the Health Maintenance Professional Services Form. The legal entity must submit changes using the Notification of Proposal Change Form.

Upon receipt of the resubmitted forms, the documents will be reviewed; acknowledgment of receipt and/or approval will be indicated by signature of the Director of Aging Services Division on the Notification of Proposal Change Form. A copy of the signed Notification of Proposal Change Form will be forwarded to the legal entity.

The new form(s) will become a part of the contract.

Options Counselor Services Form 650-25-75-05-40

The Department of Human Services, Aging Services Division, requires the completion and submission of an Options Counselor Services Form for legal entities providing options counseling services. The form identifies the individual(s) providing options counseling.

The Options Counseling Services Form will be forwarded to the legal entity through the procurement process. Throughout the contract term, the legal entity is responsible for updating and resubmission of any information contained on the Options Counseling Services Form. The legal entity must submit changes using the Notification of Proposal Change Form.

Upon receipt of the resubmitted forms, the documents will be reviewed; acknowledgment of receipt and/or approval will be indicated by signature of the Director of Aging Services Division on the Notification of Proposal Change

Form. A copy of the signed Notification of Proposal Change Form will be forwarded to the legal entity.

The new form(s) will become a part of the contract.

SAMS User License Form 650-25-75-05-45

The Department of Human Services, Aging Services Division, requires the completion and submission of a SAMS User License Form. The form identifies licensed SAMS users.

The SAMS User License Form will be forwarded to the legal entity through the procurement process. Throughout the contract term, the legal entity is responsible for updating and resubmission of any information contained on the SAMS User License Form. The legal entity must submit changes using the Notification of Proposal Change Form.

Upon receipt of the resubmitted forms, the documents will be reviewed; acknowledgment of receipt and/or approval will be indicated by signature of the Director of Aging Services Division on the Notification of Proposal Change Form. A copy of the signed Notification of Proposal Change Form will be forwarded to the legal entity.

The new form(s) will become a part of the contract.

Notification of Proposal Change Form 650-25-75-05-50

The Department of Human Services, Aging Services Division, requires the completion and submission of a Notification of Proposal Change with the applicable proposal form(s) that outlines a change(s) or update(s) to the proposal document.

The Notification of Proposal Change Form will be forwarded to the legal entity through the procurement process. Throughout the contract term, the legal entity is responsible for updating and resubmission of any changes or updates to the proposal using the Notification of Proposal Change Form.

Upon receipt of the resubmitted forms, the documents will be reviewed; acknowledgment of receipt and/or approval will be indicated by signature of the Director of Aging Services Division on the Notification of Proposal Change

Form. A copy of the signed Notification of Proposal Change Form will be forwarded to the legal entity.

The new form(s) will become a part of the contract.

Required Match 650-25-80-20

Revise third paragraph as follows:

Match is only required up to the amount that is identified in the Contract.

Supporting documentation identifying the source of the required match must be submitted on a monthly basis in the form and manner prescribed by the Department. Additional funds may be required to meet all program costs the actual cost of the provided service.

Additional Local Funds 650-25-80-21

Revise paragraphs two and three as follows:

Additional local funds should include only those costs that are directly related to providing a specific service after federal, state, required match, program income, and for nutrition contract entities, Nutrition Services Incentive Program (NSIP) funds that have been expended. Reporting costs not related to the provision of the service results in an inflated unit cost. ~~associated with defined units of service/service delivery procedures as included in each service standard. Including costs outside of the scope of the service would present an inflated unit cost. Examples of undefined units of service/service delivery procedures are as follows:~~

- ~~• costs associated with wound care/dressing changes should not be included in additional local costs for health maintenance services;~~
- ~~• costs associated with the provision of ineligible meals should not be included in additional local costs for nutrition services.~~

Additional local funds must be recorded on the Monthly Data & Payment Report as outlined in Section 650-25-85-01 of this manual. Supporting documentation identifying the source of the expended additional local funds must be submitted on a monthly basis in the form and manner prescribed by the Department.

Compensation 650-25-80-25

Revise paragraphs four and six as follows:

The Nutrition ~~contract~~ Services legal entity will receive NSIP compensation as outlined in Section 650-25-80-05, Nutrition Services Incentive Program.

The State will make payment within 30 days after the receipt of the request for reimbursement and required reporting, except that no payment will be made until the reimbursement and required reporting have been approved by the State.

Non-payment or recapture of payment may result if the ~~contract~~ legal entity fails to meet terms identified in the Contract.

Effective Date: January 1, 2014